IDAHO DEPARTMENT OF
HEALTH & WELFARE

C.L. "BUTCH" OTTER– Governor
RICHARD M. ARMSTRONG – Director

DEBBY RANSOM, R.N., R.H.I.T – Chief
BUREAU OF FACILITY STANDARDS
3232 Elder Street
P.O. Box 83720
Boise, Idaho 83720-0036
PHONE: (208) 334-6626
FAX: (208) 364-1888
E-mail: fsb@idhw.state.id.us

May 30, 2007

Barbara Pruitt, Administrator
Ashley Manor Care Centers Inc - Highmont
11099 Highmont
Boise, ID 83713

License #: RC-598

Dear Ms. Pruitt:

On April 13, 2007, a complaint investigation survey was conducted at Ashley Manor Care Centers Inc - Highmont. As a result of that survey, deficient practices were found. The deficiencies were cited at the following level(s):

- Non-core issues, which are described on the Punch List, and for which you have submitted evidence of resolution.

This office is accepting your submitted evidence of resolution.

Should you have questions, please contact Karen McDannel, RN, Health Facility Surveyor, Residential Community Care Program, at (208) 334-6626.

Sincerely,

Karen McDannel, RN

KAREN MCDANNEL, RN
Team Leader
Health Facility Surveyor
Residential Community Care Program

KM/sc

c: Jamie Simpson, MBA, QMRP Supervisor, Residential Community Care Program

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May 7, 2007

Barbara Pruitt, Administrator
Ashley Manor Care Centers Inc - Highmont
11099 Highmont
Boise, ID 83713

Dear Ms. Pruitt:

On April 13, 2007, a complaint investigation survey was conducted at Ashley Manor Care Centers Inc - Highmont. The facility was found to be providing a safe environment and safe, effective care to residents.

Please bear in mind that non-core issue deficiencies were identified on the punch list, a copy of which was reviewed and left with you during the exit conference. The completed punch list form and accompanying evidence of resolution (e.g., receipts, pictures, policy updates, etc.) are to be submitted to this office by May 13, 2007.

Should you have any questions about our visit, please contact me at (208) 334-6626.

Sincerely,

JAMIE SIMPSON, MBA, QMRP
Supervisor
Residential Care Assisted Liviing Program

JS/slc

Enclosure

IDAHO DEPARTMENT OF
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May 7, 2007

Barbara Pruitt, Administrator
Ashley Manor Care Centers Inc - Highmont
11099 Highmont
Boise, ID 83713

Dear Ms. Pruitt:

On April 13, 2007, a complaint investigation survey was conducted at Ashley Manor Care Centers Inc - Highmont. The survey was conducted by Sydnie Braithwaite, RN, Polly Watt-Geier, MSW and Karen McDannel, RN. This report outlines the findings of our investigation.

Complaint # ID00002628

Allegation #1: The facility failed to protect a resident when there was an allegation of abuse.

Findings: Refer to the Non-Core Issues Punch List.

Conclusion: The facility was issued a deficiency at IDAPA 16.03.22.153.01 for not following the facility's policy and procedure to assure residents were protected during an allegation of abuse. The facility was required to submit evidence of resolution within 30 days.

Allegation #2: The facility failed to fill out an incident report when there was an allegation of abuse.

Findings: Refer to the Non-Core Issues Punch List.

Conclusion: The facility was issued a deficiency at IDAPA 16.03.22.350 for not completing an incident report regarding an allegation of abuse. The facility was required to submit a evidence of resolution within 30 days.

Allegation #3: The facility failed to notify Area Office of Aging when there was an allegation of abuse.

Findings: Refer to the Non-Core Issues Punch List.

Conclusion: The facility was issued a deficiency at IDAPA 16.03.22.215.07 for not notifying the Area Office of Aging when there was an allegation of abuse. The facility was required to submit a evidence of resolution within 30 days.

Allegation #4: The facility failed to send an incident report regarding and unknown bruising of a resident's wrist the the licensing and survey agency.

Findings: Refer to the Non-Core Issues Punch List.

Conclusion: The facility was issued a deficiency at IDAPA 16.03.22.350.07 for not reporting an incident to the licensing and survey agency, when there had been unknown bruising found on a resident's wrist. The facility was required to submit a evidence of resolution within 30 days.

Based on the findings of the complaint investigation, the facility was found to be out of compliance with the rules for Residential Care or Assisted Living Facilities in Idaho. A Statement of Deficiencies has been issued to your facility. Please develop a Plan of Correction as outlined in the cover letter to the Statement of Deficiencies. and/or Non-core issues were identified and included on the Punch List.

If you have questions or concerns regarding our visit, please call us at (208) 334-6626. Thank you for the courtesy and cooperation you and your staff extended to us while we conducted our investigation.

Sincerely,

Karen McDannel, RN

KAREN MCDANNEL.RN
Team Leader
Health Facility Surveyor
Residential Community Care Program

KM/sc

c: Jamie Simpson, MBA, QMRP, Supervisor, Residential Community Care Program

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May 7, 2007

Barbara Pruitt, Administrator
Ashley Manor Care Centers Inc - Highmont
11099 Highmont
Boise, ID 83713

Dear Ms. Pruitt:

On April 13, 2007, a complaint investigation survey was conducted at Ashley Manor Care Centers Inc - Highmont. The survey was conducted by Sydnie Braithwaite, RN, Polly Watt-Geier, MSW, and Karen McDannel, RN. This report outlines the findings of our investigation.

Complaint # ID00002631

Allegation #1: Three residents' have not been bathed in over 1 week due to low staffing.

Finding: On April 11, 2007 through April 13, 2007, four sampled residents' records were reviewed for January and February 2007. The residents records revealed that three of the identifed resident's had not received baths for a period of seven days or longer.

Further review of the residents' records for March 2007 and April 2007 revealed residents had received their baths according to their NSA's.

Conclusion: Substantiated. However, the facility was not cited as they acted appropriately by following their policy and ensuring the residents' were bathed 2 to 3 times a week and as needed.

Allegation #2: An identified resident had a fall on February 7, 2007, he needed the assistance of two caregivers to help him up off the floor. He had to wait until a second caregiver arrived to the facility to be assisted off the floor.

Findings: On April 11, 2007, the facility's incident and accident reports for January and February 2007 were reviewed. There was no documented evidence the resident had experienced a fall.

The identified resident's NSA dated January 2007, revealed the resident required a one person assist for his activities of daily living (ADL's).

On April 11, 2007 and April 12, 2007, two caregivers and the house manager were interviewed. They stated the resident had not fallen, and that the resident was a one person assist and did not require assistance of two caregivers.

Conclusion: Unsubstantiated. Although it may have occurred, it could not be determined during the complaint investigation.

Allegation #3: An identified resident had a significant change in health status, requiring total assist with all ADL's. The facility nurse has not done an assessment or updated his Negotiated Service Agreement (NSA) or temporary care plan.

Findings: On April 11, 2007, the identified resident's NSA was reviewed. It documented the resident had not experienced a significant change in health status.

Review of the Janurary 2007 nursing assessment revealed the resident did not have a significant change in health status.

Review of the resident's progress notes from January 2007 through March 2007 revealed no documented evidence the resident had a significant change in health status.

On April 11, 2007 and April 12, 2007, two caregivers and the house manager were interviewed. They stated the resident had not had a significant change in health status.

Conclusion: Unsubstantiated. Although it may have occurred, it could not be determined during the complaint investigation.

Allegation #4: An identified resident had a strong urine smell and caregivers do not have time to clean and take care of the resident's room.

Findings: Refer to the Non-Core Issues Punch List.

Conclusion: Substantiated. The facility was issued a deficiency at IDAPA 16.03.22.260.06 for failure to maintain the interior of the facility in a clean manner. The facility was required to submit evidence of resolution within 30 days.

Allegation #5: Staff had not been trained or received 16 hours of orientation since being hired. Additionally, the house manager had not received her medication certification before assisting residents' with medications.

Findings: On April 11, 2007, five personal records were reviewed for March and April 2007. The personnel records revealed that all current staff had received 16 hours of orientation. Also, the current house manager's personnel record revealed she had obtained the medication certification before assisting residents' with medications.

Conclusion: Unsubstantiated. Although it may have occurred, it could not be determined during the complaint investigation.

Allegation #6: The facility's contract nurse had not delegated to any of the caregivers.

Findings: On April 11, 2007, the facility's personel records were reviewed for March and April 2007. The records revealed that all current staff had nurse delegation.

On April 11, 2007 at 10:45 a.m., the house manager confirmed all current staff had nurse delegation.

Conclusion: Unsubstantiated. Although it may have occurred, it could not be determined during the complaint investigation.

Allegation #7: An identified resident needed to be supervised while smoking and caregivers would go outside with the resident while he smoked and the caregiver would watch the other residents' through the glass door to ensure the residents inside were safe.

Findings: The identified resident's closed record was reviewed on April 11, 2007, and revealed the resident needed supervision for smoking.

On April 11, 2007, two caregivers and the house manager were interviewed regarding the identified resident's smoking. They stated the resident did require supervision while smoking and only smoked outside on the patio in their line of sight.

Conclusion: Unsubstantiated. Although it may have occurred, it could not be determined during the complaint investigation.

Allegation #8: An identified resident required the use of a gait belt for transfers and mobility.

Findings: The identified resident's NSA was reviewed. It documented the resident required a one person transfer and was able to ambulate about the facility independently.

On April 11, 2007 at 11:03 a.m., two caregivers and the house manager were interviewed. They stated the resident did not require the use of a gait belt for transfers, but needed assistance of one person for transfers. They further stated the resident was independent with ambulation in the facility.

Conclusion: Unsubstantiated. Although it may have occurred, it could not be determined during the complaint investigation.

Allegation #9: A resident did not have her teeth brushed for approximately 3 weeks.

Findings: Refer to the Non-Core issues Punch List.

Conclusion: Substantiated. The facility was issued a deficiency at IDAPA 16.03.22.305.01 for not having the facility nurse assess and ensure the identified resident received the needed prescribed dental care.

Allegation #10: An identified resident was physically aggressive toward caregivers and other residents and did not have a behavior management plan (BMP) to direct staff on how to intervene with the resident.

Findings: The identified resident's NSA was reviewed and did include a behavior management plan that directed staff how to intervene when the resident would become aggressive.

On April 11, 2007 at 11:10 a.m., two caregivers and the house manager were interviewed. They stated the resident was not aggressive at this time, and staff were trained in how to intervene if he became aggressive towards staff or residents.

Conclusion: Unsubstantiated. Although it may have occurred, it could not be determined during the complaint investigation.

Based on the findings of the complaint investigation, the facility was found to be out of compliance with the rules for Residential Care or Assisted Living Facilities in Idaho. A Statement of Deficiencies has been issued to your facility. Please develop a Plan of Correction as outlined in the cover letter to the Statement of Deficiencies. and/or Non-core issues were identified and included on the Punch List.

If you have questions or concerns regarding our visit, please call us at (208) 334-6626. Thank you for the courtesy and cooperation you and your staff extended to us while we conducted our investigation.

Sincerely,

Karen McDannel, RN

KAREN MCDANNEL, RN
Team Leader
Health Facility Surveyor
Residential Community Care Program

KM/sc

c: Jamie Simpson, MBA, QMRP, Supervisor, Residential Community Care Program

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(208) 334-6626 fax: (208) 364-1888

ASSISTED LIVING
Non-Core Issues
Punch List

Facility Name	Physical Address	Phone Number
Ashley Manor - Highmont	11099 Highmont Drive	(208) 377-4107
Administrator	**City**	**ZIP Code**
Barbara Pruitt	Boise	83713
Survey Team Leader	**Survey Type**	**Survey Date**
Karen McDaniel	Complaint Investigation	4-13-07

NON-CORE ISSUES

ITEM #	RULE # 16.03.22	DESCRIPTION	DATE RESOLVED	BFS USE
1	210.	The facility did not ensure that meaningful activities were provided to 9 of 9 residents (100%).		
2	250.14	The facility failed to maintain a secure environment for residents who were cognitively impaired by leaving windows open to the street & additionally the door in laundry room connecting to office & Garage was observed on 4/11 - 4/12/07 propped open, leading to street side of facility.		
3	215.07	The administrator did not ensure Adult Protection was notified when there was an allegation of abuse by ~~a~~ Caregiver.		
4	350.	The facility caregivers did not ~~to~~ complete an incident report regarding an allegation of abuse		
5	350.07	The administrator did not report to the Bureau of Facility Standards an incident report regarding a resident that had unknown bruising on bilateral wrists.		

Response Required Date	Signature of Facility Representative	Date Signed
5-13-07	B. Pruitt	4-13-07

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ASSISTED LIVING
Non-Core Issues Punch List

Facility Name	Physical Address	Phone Number
Ashley Manor - Highmont	11099 Highmont Drive	(208) 377-4107
Administrator	**City**	**ZIP Code**
Barbara Pruitt	Boise	83713
Survey Team Leader	**Survey Type**	**Survey Date**
Karen McDaniel	Complaint Investigation	4-13-07

NON-CORE ISSUES

ITEM #	RULE # 16.03.22	DESCRIPTION	DATE RESOLVED	BFS USE
6a	260.06	The facility failed to maintain the interior of the facility in a clean, safe manner. (ie:) Resident #3 bathroom & toilet were observed to have a liquid substance around base of the toilet. There was a brown built up ring inside toilet bowel. The bedroom baseboard near bathroom had a dried yellow stain (approx 1 foot in length), the carpet had one continous stain the room had a strong urine smell that lingered into the dining room area. Six additional toilets in the facility had built up brown stains inside bowels; two toilets had brown stains on back of toilet seat; One toilet had a large amount of a yellow dried stain around base of the toilet.		
7	730.02	The facility did not maintain an up to date worked schedule for 3 days to reflect caregivers on duty.	4-13-07	

Response Required Date	Signature of Facility Representative	Date Signed
5-13-07	B. Pruitt	

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ASSISTED LIVING
Non-Core Issues Punch List

Facility Name	Physical Address	Phone Number
Ashley Manor Highmont	11099 Highmont Drive	(208) 377-9107
Administrator	**City**	**ZIP Code**
Barbara Pruitt	Boise	83713
Survey Team Leader	**Survey Type**	**Survey Date**
Karen McDaniel	Complaint Investigation	4-13-07

NON-CORE ISSUES

ITEM #	RULE # 16.03.22	DESCRIPTION	DATE RESOLVED	BFS USE
8	153.01	The facility did not follow their policy & procedures to assure residents were protected during an allegation of abuse investigation involving a caregiver and resident.		

Response Required Date	Signature of Facility Representative	Date Signed
5-13-07	B. Pruitt 4-13-07	

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Barbara Pruitt	Boise	83713
Survey Team Leader	**Survey Type**	**Survey Date**
Karen McDaniel	Complaint Investigation	4/13/07

NON-CORE ISSUES

ITEM #	RULE #	DESCRIPTION	DATE RESOLVED
89	305.01	The facility's RN did not conduct a nursing assessment to ensure an identified resident received the needed prescribed dental care.	
		(4/23/07) The core deficiency citation was reduced to the above punch, item # 89	

Response Required Date	Signature of Facility Representative
5/13/07	